STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155679	A. BUILDING _____ B. WING _____	03/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHLEHEM WOODS NURSING AND REHABILITATION CENTE	4430 ELSDALE DR FORT WAYNE, IN46835

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 21, 22, 23, & 24, 2011 Facility number: 000260 Provider number: 155679 AIM number: 100267820 Survey team: Sue Brooke,r RD TC Rick Blain, RN Christine Fodrea, RN Sheryl Roth, RN Census bed type: SNF/NF: 86 Total: 86 Census payor type: Medicare: 8 Medicaid: 59 Other: 19 Total: 86 Sample 18: Supplemental sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.The provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation.Based on past survey history and no harm identified to any resident; this facility respectfully requests a desk review in lieu of a post survey revisit on or before April 15, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on March 27, 2011 by Bev Faulkner, RN			

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F0514 SS=D	Based on observation, record review and interview, the facility failed to ensure a thorough and comprehensive clinical record, supplying readily accessible sufficient information for 1 of 1 residents in a supplemental sample with a wound/scab. (Resident #5) Findings include: On 3/21/11 at 7:50 a.m., a red open area the size of a quarter was noted to the center of the forehead of Resident #5. The skin around the perimeter of the area was pink in color. Also noted were abrasions over the left eyebrow. Review of the clinical record of Resident #5 on 3/21/11 at 10:00 a.m. and on 3/23/11 at 2:00 p.m., indicated the following: Resident #5's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and atrial fibrillation. The "Interdisciplinary Team Progress Notes," dated "3/1/11," under social services, indicated Resident #5 "...explained her cont. (continued) back pain and her eye burns - per DNS (Director of Nursing Services) will refer to NP (Nurse Practitioner)...."	F0514	F 0514 It is the practice of this provider to ensure a thorough and comprehensive clinical record, supplying readily accessible sufficient information for all residents.What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:The skin assessment, nurses notes and wound skin evaluation report for Resident #5 is available in the clinical record. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken: All residents with skin alterations have the potential to be affected by the alleged deficient practice. The clinical records for residents with skin alterations will be audited no less than weekly to ensure records are complete and accurately documented.The clinical records will be maintained and kept readily accessible and systematically organized.Education will be completed by April 15, 2011 for all licensed nurses and Medical Records personnel by the Director of Nursing. Education will include accurately documenting complete skin assessments, nurses' notes and wound skin evaluation reports, review of the Skin Management Program and maintaining readily	04/15/2011

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	During the record review on 3/21/11 at 10:00 a.m. and 3/23/11 at 2:00 p.m., the only notes in the clinical record regarding the wound/scab/abrasions to Resident #5's forehead were the following, none of which explained how the wound/scab was acquired: - "Nurses Notes," dated 3/20/11 12:30 a.m., signed by LPN #1, did not contain any information related to the resident's forehead, scab, breathing treatment or problems with breathing mask. - "Nurses Notes," dated 3/21/11 at 5:00 p.m., signed by LPN #2, indicated Resident #5 had a scab to her forehead. - "Nurses Notes," dated 3/22/11 at 2:15 a.m., indicated Resident #5 had an intact scab to her forehead with no drainage or discomfort. - "Nurses Notes," dated 3/22/11 at 9:00 a.m., indicated a scab continued to Resident #5's forehead. The skin was slightly red but intact and a new order was obtained for antibiotic ointment and Band-Aid daily until resolved. - The physician signed,"Interdisciplinary Progress Note," dated 3/22/11, indicated on exam, Resident #5 had scabbed		accessible and systematically organized records.What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur:The clinical records for residents with skin alterations will be audited no less than weekly to ensure records are complete and accurately documented. The clinical records will be maintained and kept readily accessible and systematically organized.Education will be completed by April 15, 2011 for all licensed nurses and Medical Records personnel by the Director of Nursing. Education will include accurately documenting complete skin assessments, nurses' notes and wound skin evaluation reports, review of the Skin Management Program and maintaining readily accessible and systematically organized records.How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur:A CQI monitoring tool will be utilized every week x 4, monthly x 3 and quarterly thereafter.Data will be submitted to the CQI committee. If threshold is not met, an action plan will be developed.Non-compliance with facility policy/procedure may result in disciplinary action and/or re-education.	

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	excoriations to midbrow and left brow. - "Nurses Notes," dated 3/22/11 at 10:00 p.m., indicated a Band-Aid was observed to the scab on Resident #5's forehead. - And the last entry on the page was noted 3/23/11 at 9:00 a.m., followed by five blank lines. The note indicated the scab continued to Resident #5' forehead and the skin was slightly red around the area. Not available on the clinical record at the time of record review was the "Weekly Skin Assessment," dated 3/20/11 signed by LPN #1 with no time listed, which was provided by the Director of Nursing on 3/24/11 at 12:00 p.m.. The assessment indicated Resident #5 had a discoloration/rash described as "slight pink area noted between eyebrows...noted resident scratching, skin intact, then scabbed in the A.M...." The "Peer Review Document," dated 3/20/11, with no time listed, which is not a part of the clinical record and is used for internal facility quality improvement, was provided by the Director of Nursing on 3/24/11 at 12:00 p.m. The documented listed that during a breathing treatment, Resident #5 complained of the mask poking her forehead. The mask was			

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	checked with no sharp areas noted. The nurse then replaced the mask with a new one after the breathing treatment was finished. The note further indicated the resident continued to scratch between her eyebrows causing the area to be pink with intact skin. "Resident in the morning to have smooth brown scab intact between brows...no drainage or redness noted...." The note was signed by the nurse on duty during the shift (LPN #1). Also not available on the clinical record, or in the acute charting book during the time of record review, was a sheet of nurses notes, dated 3/11/11 thru 3/21/11, which were provided by the Director of Nursing (DON) on 3/24/11 at 10:30 a.m. The DON indicated at that time, she had been reviewing the documents and wasn't aware of anyone looking for them so they weren't in the clinical record. The notes included the following: - The "Nurses Notes," dated 3/20/11 at 9:00 a.m., indicated an area on the forehead was dark and appeared to be scabbed for Resident #5. - "Nurses Notes," dated 3/21/11 at 9:00 a.m., indicated scab continues to forehead. A "Wound Skin Evaluation Report," dated			

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	3/21/11, signed by the Assistant Director of Nursing/Wound Nurse did not list a time of the assessment. This note was also not available during the time of record review but was provided by the Assistant Director of Nursing/Wound Nurse on 3/24/11 at 11:45 a.m. The note indicated Resident #5 had an abrasion/scab measuring 3.4 a.m. by 2.6 c.m. with a depth of less than 0.1 c.m. with a dark brown intact scab. On 3/24/11 at 10:20 a.m., Resident #5 indicated she obtained the scab to her forehead when staff gave her a breathing treatment recently and the mask was too tight and was poking her. She further stated the mask was changed to a new one but when they applied the new mask, it again was too tight. On 3/24/11 at 11:25 a.m., the Director of Nursing indicated there was no need for further documentation since there was nothing on the skin at the time of the incident to show there was anything open areas. She stated when the resident went to bed that evening (3/19/11)there was nothing on her forehead and the skin was intact but when the first shift came on (3/20/11), the scab was noted. She stated the scab was considered intact so there was no need for further documentation of			

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	the wound. The current policy titled "Skin Management Program,", dated 3/10, was provided by the Director of Nursing on 3/24/10 at 10:40 a.m. The policy indicated "...Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include bruises, open areas, redness, skin tears, blisters, and rashes...The licensed nurse is responsible for assessing any and all skin alterations as reported by the direct caregivers on the shift reported...." 3.1-50(a)(1) 3.1-50(a)(3)			